

Successful use of valciclovir in a case of recurrent urticaria associated with genital herpes

Urticaria is a common skin condition but the symptoms and signs can be extremely distressing. The condition is often idiopathic.¹ The management of urticaria can be frustrating even when triggers are identified.² We describe a case of recurrent urticaria associated with genital herpes attacks and a successful use of suppressive therapy with valciclovir.

A 35 year old white woman presented in March 2000 to a genitourinary medicine (GUM) clinic with 5 year history of recurrent lesions typical of genital herpes simplex virus (HSV) infection occurring almost every month. She had also been developing physical urticaria manifesting as itchy wheals on pressure areas of the body, approximately 24 hours before the onset of genital HSV attacks. The lesions showed no characteristics of erythema multiforme or vasculitis. Each urticarial attack lasted from 20–30 minutes and had a cholinergic element being exacerbated by exercise and heat. Antihistamines were not effective. She had contact sensitivity to perfumes, make up, and coloured bath products. There was no history of angioedema, other atopic disease, or drug allergies. She was otherwise well and on no medication.

Culture for HSV was negative. However, serology was positive for HSV type 1 IgG antibody. HSV type 2, hepatitis B and C serology were negative. Her IgE level was normal. Immunological investigations including CD4/CD8 count showed no evidence of immunodeficiency.

Her HSV attacks were frequent and distressing. She began suppressive therapy with valciclovir 500 mg twice a day and antihistamines in March 2000 and the symptoms were well controlled. Both urticaria and herpes recurred when the valciclovir therapy was discontinued after 6 months. She recommenced her therapy in October 2000 but required higher doses of valciclovir to control her symptoms. She is currently taking valciclovir 1 g twice daily and cetirizine 10 mg daily. She had a single episode of urticaria associated with genital herpes precipitated by intense sunlight exposure in September 2001 and had no further attacks since then.

Urticaria can be triggered by a large number of diverse allergens including sexually transmitted infections such as hepatitis B virus.³ A case of chronic urticaria preceding genital herpes and a successful treatment with a short course of aciclovir has been described. However, the long term follow up of this patient was not known.⁴ A recent study in Ohio has reported a successful use of maintenance therapy with aciclovir in five out of 12 patients with chronic urticaria; none had genital herpes.⁵ In our patient, control of both genital herpes and recurrent urticaria with valciclovir therapy suggests a close temporal

association between the onset of urticaria and development of herpetic lesions. The exact role of HSV in the pathogenesis of urticaria is unknown but it may be related to hypersensitivity reaction to viral antigens. Antiviral agents may be effective by suppressing these antigens.

This case demonstrates the importance of early recognition of urticaria associated with HSV infections in order to avoid delay in instituting antiviral treatment in GUM clinics or other settings for this disabling skin condition.

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Inhibition of *Neisseria gonorrhoeae* by vaginal lubricants

Microbiology culture remains the diagnostic standard for gonococcal infection. Isolation of the pathogen confirms the clinical diagnosis and allows assessment of the antimicrobial susceptibility of the gonococcal strain, guiding effective therapy. The sensitivity of endocervical swab culture has been reported as 80–90% but this varies with the quality of culture media and adequacy of the specimen.¹ The gonococcus is a nutritionally demanding bacterium, readily inhibited by adverse culture conditions.

For decades, doctors in genitourinary medicine have been advised to lubricate metal vaginal specula with water only. With the increasing use of disposable vaginal specula, which are more difficult to insert, some workers have promoted the use of vaginal lubricants, such as KY jelly, to reduce patient discomfort during clinical examination and specimen collection.

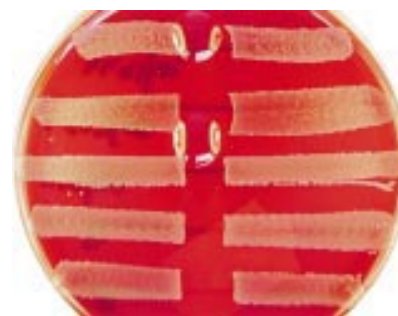


Figure 1 Five randomly selected clinical strains of *Neisseria gonorrhoeae* growing on gonococcal sensitivity agar. Note the central region of the plate where a line of KY jelly has inhibited growth.

Figure 1 shows five randomly selected clinical strains of *Neisseria gonorrhoeae* inoculated by swab (10^3 /ml) and growing readily on gonococcal sensitivity agar except in the central region of the plate where a line of KY jelly has inhibited growth.

Some studies have demonstrated the inhibitory actions of various vaginal lubricants, including KY jelly, against *N. gonorrhoeae*,² while others have found KY jelly to be relatively non-toxic to both chlamydia and gonococci.³

In view of these conflicting findings, prospective studies are required to assess the clinical significance of using vaginal lubricants when collecting specimens for gonococcal culture. Pending the completion of such studies we recommend that vaginal lubricants should not be used when obtaining endocervical samples for microbiological investigation.

Contributors

REH, design of practical work, literature review, production of first draft of manuscript; JDJ, performance of practical work, literature review, critical comment on draft manuscript; FD identification of clinical issue, literature review, critical comment on draft manuscript.

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